Dept of Labor and Industries
Crime Victims Compensation (CVC)
PO Box 44520
Olympia WA 98504-4520

STATEMENT FOR PHARMACY SERVICES

This form to be used for CRIME VICTIMS claims only

SOC. SEC. NO. (FOR I.D. ONLY)	CLAIM NO.

PHARMACY NAME & ADDRESS	CVC PROVIDER #	CLAIMANT'S NAME (LAST, FIRST, MIDDLE)		
		ADDRESS		
		CITY	STATE	ZIP
	TAX ID #	BILL DATE	AMOUNT PAID BY COLLATERAL RESOURCES	$

REIMBURSE CLAIMANT YES ☐ NO ☐ AMOUNT PAID BY CLAIMANT $

PRESCRIPTION DETAIL

PRINT OR TYPE ALL INFORMATION

DX CODE (ICD-9)	S/B	DATE OF INJURY	DATE WRITTEN	PRESCRIBING PROVIDER'S NAME AND NUMBER		DRUG COST	
PRESCRIPTION NO.	DATE FILLED	EST. DAYS SUPPLY	QUANTITY	REFILL YES ☐ NO ☐	GENERIC SUBSTITUTION ALLOWED? YES ☐ NO ☐	PROFESSIONAL FEE	
NATIONAL DRUG CODE	DRUG NAME					APPLICABLE TAX	
REMARKS						PRESCRIPTION TOTAL	

DX CODE (ICD-9)	S/B	DATE OF INJURY	DATE WRITTEN	PRESCRIBING PROVIDER'S NAME AND NUMBER		DRUG COST	
PRESCRIPTION NO.	DATE FILLED	EST. DAYS SUPPLY	QUANTITY	REFILL YES ☐ NO ☐	GENERIC SUBSTITUTION ALLOWED? YES ☐ NO ☐	PROFESSIONAL FEE	
NATIONAL DRUG CODE	DRUG NAME					APPLICABLE TAX	
REMARKS						PRESCRIPTION TOTAL	

DX CODE (ICD-9)	S/B	DATE OF INJURY	DATE WRITTEN	PRESCRIBING PROVIDER'S NAME AND NUMBER		DRUG COST	
PRESCRIPTION NO.	DATE FILLED	EST. DAYS SUPPLY	QUANTITY	REFILL YES ☐ NO ☐	GENERIC SUBSTITUTION ALLOWED? YES ☐ NO ☐	PROFESSIONAL FEE	
NATIONAL DRUG CODE	DRUG NAME					APPLICABLE TAX	
REMARKS						PRESCRIPTION TOTAL	

PROVIDER CERTIFICATION

Submission of the bill certifies the material furnished, service provided, expense incurred, or other item of indebtedness as charged in the forgoing bill is a true and correct charge against the state of Washington; that the claim is just and true; that no part of the same has been paid.

REMARKS:

REFUND CERTIFICATION

I hereby certify under penalty of perjury that this is a true and correct claim for necessary expenses incurred by me; that the claim is just and due and that no payment has been received by me on account thereof.

CLAIMANT'S SIGNATURE:

I hereby certify under penalty of perjury that the claimant has paid for the prescription(s) furnished.

PHARMACIST'S SIGNATURE:

CLAIMANT NUMBER V-

INSTRUCTIONS FOR STATEMENT OF PHARMACY SERVICES

SOCIAL SECURITY NUMBER: I.D. only for the claimant.

CLAIM NUMBER: For the claimant receiving services.

CRIME VICTIMS

Crime victim claim numbers are six digits preceded by a "V", or five digits preceded by a "VA, VB, VC or VH".

Send bills for Crime Victims claims to:

Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

STATE FUND INDUSTRIAL INSURANCE

Claim numbers are six digits, preceded by a "B, C, F, G, H, J, K, L, M, N or P." Department of Energy claims are seven digits with no Alpha designation.

Send bills for Industrial Insurance claims to:

Department of Labor and Industries
PO Box 44268
Olympia WA 98504-4268

Department bill forms are furnished at no charge to the vendor and can be obtained by calling the local department service location.

SELF-INSURANCE

Self-insurance claim numbers are six digits preceded by an "S, T or W". Bills for **ALL** self-insurance claims should be sent directly to the employer or their service company. Department bill forms, self-insured forms, or other forms acceptable to the self-insurer may be used.

PHARMACY NAME AND ADDRESS: The pharmacy filling the prescription. If your name, address or business status changes, send notification immediately to:

Crime Victims Compensation Program
Department of Labor and Industries
PO Box 44520
Olympia WA 98504-4520

*(Simply indicating a new address on the bill **will not** change the Department's record of address for the supplier.)*

CRIME VICTIMS PROGRAM PROVIDER NUMBER: The specific provider number designated by the Crime Victims Program for the supplier.

CLAIMANT'S NAME: The claimant's full name, last name first.

ADDRESS: The claimant's most current address.

BILL DATE: Date the supplier is completing the form.

AMOUNT PAID BY COLLATERAL RESOURCES: Indicate amount paid by primary insurance (collateral resource)

REIMBURSE CLAIMANT: Place an "X" in the "Yes" box if payment of this prescription should be paid to the claimant. Indicate amount claimant has paid. Sign the "Refund Certification" boxes.

DIAGNOSIS CODE (ICD-9): The ICD-9 code for the condition treated.

S/B (SIDE OF BODY): Designate left or right side of body where injury occurred.

DATE OF INJURY: This is important as claimant may have several claims; the proper claim must be identified and charged for services provided.

DATE WRITTEN: Date the doctor wrote the prescription.

PRESCRIBING PROVIDER'S NAME AND NUMBER: Name of the prescribing provider and the account number issued to the provider by Crime Victims.

DRUG COST: The cost of the medication before professional fees and taxes have been included.

PRESCRIPTION NUMBER: Prescription identification number (Rx No.).

DATE FILLED: Date the prescription is filled.

ESTIMATED DAYS SUPPLY: Refers to the total number of days the prescription is intended to cover.

QUANTITY: The total units of medication prescribed. Use the National Council for Prescription Drug Programs (NCPDP) billing unit standard format, e.g., "each", "ml", or "gm".

REFILL: Place an "X" in the applicable box.

GENERIC SUBSTITUTION ALLOWED: Place an "X" in the applicable box.

PROFESSIONAL FEE: Added cost for the services provided by the pharmacist.

NATIONAL DRUG CODE: National drug identification code.

NAME OF DRUG: Name of medication dispensed.

TAX: Applicable sales tax.

REMARKS: Any information the doctor or pharmacist feels is necessary for further explanation.

PRESCRIPTION TOTAL: Total charge for the filled prescription.

REFUND CERTIFICATION— FOR CLAIMANT REIMBURSEMENT, COMPLETE THE FOLLOWING:

A. CLAIMANT'S SIGNATURE: Signature of the claimant for which the prescription was filled.

B. PHARMACIST'S SIGNATURE: Signature of pharmacist who supplied the prescription.